MAINE CANCER REGISTRY
Physician Report Form, 08/2004

Please submit form to: DAWN NICOLAIDES, CTR
MAINE CANCER REGISTRY, DHHS
KEY PLAZA – 4TH FLOOR
11 STATE HOUSE STATION
AUGUSTA, ME 04333-0011
PHONE: 207-287-4742

PHYSICIAN NAME
PHYSICIAN LICENSE #
PHYSICIAN ADDRESS

PATIENT INFORMATION

LAST name	FIRST NAME	MIDDLE NAME	MAIDEN NAME
NAME SUFFIX (SR. JR, III ETC)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	Sex ☐ 1 Male ☐ 2 Female ☐ 3 Other ☐ 4 Transexual ☐ 9 Unknown

Race	Hispanic	Usual Occupation – text
☐ 1 White ☐ 2 Black ☐ 3 Native American ☐ 96 Asian ☐ 9 Unknown ☐ Other _____	☐ 1 Yes ; If yes, ethnicity_____ ☐ 2 No ☐ 9 Unknown	_____ Usual Industry – text _____

Address at diagnosis
Street City State Zip

Current address, if different from above
Street City State Zip

CANCER INFORMATION

Date of Diagnosis (mm-dd-yyyy) Date first seen for this cancer (mm-dd-yyyy)	Primary Site (text description)	Histology or Morphology (text)

Laterality (check one)	Grade Code	Behavior Code	What number cancer is this (1st, 2nd, 3rd, etc)?
☐ 0 N/A ☐ 1 Right ☐ 2 Left ☐ 3 One side, unknown which ☐ 4 Bilateral ☐ 9 Paired organ, no information re laterality	☐ 1 Well differentiated ☐ 5 T-Cell ☐ 2 Moderately well differentiated ☐ 6 B-Cell ☐ 3 Poorly differentiated ☐ 7 Null Cell ☐ 4 Undifferentiated, Anaplastic ☐ 9 Unknown or N/A	☐ 0 = Benign ☐ 1 = Uncertain ☐ 2 = In - situ ☐ 3 = Malignant	

General Summary Stage Code	Pathologic TNM, AJCC Stage	Clinical TNM, AJCC Stage
	T Code _____N Code _____ M Code _____ Group _____	T Code _____ N Code _____ M Code _____Group _____

Text to substantiate the Stage of Disease

DIAGNOSTIC INFORMATION

HISTOLOGY (TISSUE SAMPLE) ☐ YES ☐ NO	DATE
TEXT DESCRIPTION	

CYTOLOGY (FNA, SPUN CELLS) ☐ YES ☐ NO	DATE
TEXT DESCRIPTION	

RADIOLOGY, SCANS, ULTRA SOUND ☐ YES ☐ NO	DATE
TEXT DESCRIPTION	

VISUALIZATION (E.G. ENDOSCOPY) ☐ YES ☐ NO	DATE
TEXT DESCRIPTION	

CLINICAL (INC. PHYS. EXAM) ☐ YES ☐ NO	DATE
TEXT DESCRIPTION	

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PHYSICIAN NAME

PATIENT INFORMATION, CONTINUED

LAST name	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER

FIRST COURSE OF TREATMENT INFORMATION COMPLETE ONLY THE FOLLOWING WHICH APPLY TO THIS PATIENT

CANCER DIRECTED SURGERY ☐ YES ☐ NO	DATE OF CANCER DIRECTED SURGERY
SURGICAL PROCEDURE TEXT	

RADIATION THERAPY ☐ YES ☐ NO	DATE OF RADIATION THERAPY
RADIATION THERAPY TEXT	

CHEMOTHERAPY ☐ YES ☐ NO	DATE OF CHEMOTHERAPY
CHEMOTHERAPY TEXT	

HORMONE THERAPY ☐ YES ☐ NO	DATE OF HORMONE THERAPY
HORMONE THERAPY TEXT	

BIOLOGICAL RESPONSE MODIFIER ☐ YES ☐ NO	DATE OF BRM
BRM TEXT	

OTHER TREATMENT ☐ YES ☐ NO	DATE OF OTHER TREATMENT
OTHER TREATMENT TEXT	

FOLLOW UP INFORMATION

VITAL STATUS ☐ 1 Alive ☐ 0 Dead	DATE OF DEATH OR LAST FOLLOW-UP	TUMOR STATUS ☐ 1 No evidence of this Cancer ☐ 2 Evidence of this Cancer ☐ 9 Unknown
ICD-9-CM CODE FOR CANCER RELATED CAUSE OF DEATH:	IF DECEASED, WAS THERE AN AUTOPSY? ☐ 1 YES ☐ 2 NO ☐ UNKNOWN	
FOLLOWING PHYSICIAN'S NAME	MANAGING PHYSICIAN'S NAME	SURGEON'S NAME
REFERRING PHYSICIAN'S NAME	INSTITUTION REFERRED FROM	INSTITUTION REFERRED TO
COMMENTS:		